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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

CHRISTOPHER GOLECO, Plaintiff and Respondent, v. STATE PERSONNEL BOARD, Defendant and Respondent; DEPARTMENT OF CORRECTIONS AND REHABILITATION, Real Party in Interest and Appellant.	B240755 (Los Angeles County Super. Ct. No. BS130306)

Appeal from a judgment of the Superior Court of Los Angeles County, Ann Jones, Judge. Affirmed.

Department of Corrections and Rehabilitation, Office of Legal Affairs, Alfred Mondorf, Assistant Chief Counsel, and Stephen A. Jennings, Staff Counsel IV, for Real Party in Interest and Appellant Department of Corrections and Rehabilitation.

Adams, Ferrone, and Ferrone and Stuart D. Adams, for Plaintiff and Respondent Christopher Goleco.

Alvin Gittisriboongul, Chief Counsel, and Heather Glick, Senior Staff Counsel, for Defendant and Respondent State Personnel Board.

The California Department of Corrections and Rehabilitation (Department) dismissed Christopher Goleco from his civil service position as a medical technical assistant because he delayed administering cardiopulmonary resuscitation (CPR) to an inmate who had been strangled and beaten. After the State Personnel Board upheld the Department's decision to terminate Goleco, the superior court granted Goleco's petition for writ of administrative mandate, reinstating him with full back pay. The court found there was no substantial evidence Goleco had neglected his duty because it was clear the inmate had been dead for some time when Goleco arrived at the scene. We affirm.

FACTUAL AND PROCEDURAL BACKGROUND

1. *Goleco's Description of the Incident*

On September 10, 2004, about six months after his appointment as a medical technical assistant, Goleco was working as an ambulance driver at California State Prison, Los Angeles County, in Lancaster. Goleco responded to an alarm in an administrative segregation housing unit. Arriving at cell number 149 with his basic first aid kit and life support equipment, Goleco noticed groups of officers huddled near the cell, as well as officers taking photographs of inmate Eddie Arriaga, who was lying face down on the floor inside the cell. Goleco was confused because the officers were not acting with any sense of urgency. According to Goleco, "[E]veryone was just standing there. And the squad guys were just taking pictures. I remember Sanchez stepped over . . . [Arriaga] to place some cards next to what appeared to be brain by the toilet. And when he stepped over it, I also realized that, hey, you know, everyone's real nonchalant."

Goleco's primary duties as an ambulance driver were to transport patients and assist the medical technical assistant assigned to each housing unit. However, there was no medical technical assistant present when Goleco arrived at cell 149. Consequently, Goleco stepped into the cell to begin administering first aid. Because blood was everywhere and he did not want to contaminate his medical supply bag, Goleco placed the bag outside the cell. He came back in and checked Arriaga for a pulse and other signs of responsiveness. Finding none, Goleco told the officers who were taking photographs they needed to leave the cell so he could roll Arriaga over. Once Arriaga was on his

back, Goleco performed a final assessment, noting he had a large head wound, fixed and dilated eyes, blue skin down to his neck and extensive ligature marks. Goleco then stepped outside the cell to get supplies to treat the head wound and commence CPR. Realizing he did not have large enough bandages for the head wound and also wanting to find the unit's assigned medical technical assistant, he went to the nearby medical technical assistant's office; but the door was locked. He returned to the cell and began administering CPR.

Goleco estimates approximately five minutes elapsed from the time he first arrived at the cell until he began CPR. Acknowledging brain damage occurs after four to six minutes without breathing and it is Department policy to immediately attend to the body and begin CPR, Goleco explained, "The sooner you can do CPR the better. Always the better but do not initiate CPR if you know you have to stop doing CPR. I had no help. I can't stop and say okay wait a minute. This man [is] oozing blood, I got to run and get gauze. No, get your equipment, start so you don't have to stop. Stopping is pronouncing [dead]." With respect to Arriaga, Goleco was concerned he had to treat the head wound before performing CPR or else the artificial circulation would cause "the spurting effect" through the big gash on Arriaga's head.

After Goleco started CPR, he was joined by medical technical assistant Vanessa Vance. Vance assisted until a gurney arrived and Arriaga was taken to the central infirmary where he was pronounced dead. Arriaga's cellmate was charged with murder.

2. *The ALJ's Proposed Decision To Reject Goleco's Termination; the Personnel Board's First Decision Upholding the Termination*

In early October 2005 Goleco was served with a notice of adverse action, alleging he had failed to provide timely emergency medical treatment and dismissing him effective October 14, 2005. Goleco appealed the adverse action to the Personnel Board. During the five days of hearings before an administrative law judge (ALJ) in May, July and October 2006, the Department presented the testimony of 12 witnesses, including Goleco. Several witnesses testified Lieutenant Charles Hughes, the crime scene commander, had interfered with the medical personnel by declaring cell 149 a crime

scene because Arriaga was dead. For example, senior medical technical assistant Brenda Wimbish testified she became concerned after waiting more than 10 minutes in the emergency room for Arriaga to be transported for treatment. Unable to contact a medical technical assistant at the scene by radio, Wimbish and others rushed to cell 149 where she saw Goleco and Vance performing CPR. They told her Hughes would not allow them to move Arriaga. When Wimbish confronted Hughes, he told her to leave because Arriaga was dead and she was interfering with a crime scene. After Wimbish told Hughes no one at the scene was qualified to pronounce Arriaga dead, she was directed to speak to the associate warden. The associate warden then authorized moving Arriaga to the emergency room.

Lieutenant Raymont Henderson testified Goleco and Vance were outside the cell when he arrived at the scene and the security squad was inside taking pictures. Henderson heard Lieutenant Hughes tell Goleco and Vance they did not need the medical team because Arriaga was dead and the security squad was going to continue to take pictures.

Although Goleco presented no additional testimony in his defense, he submitted seven exhibits including the Institution's Emergency Response Review Committee (IERRC) Guidelines. Those guidelines state, "[CPR] shall be initiated in all cases of cardiac/respiratory arrest, except when the following signs of death are present: [¶] Signs of Death [¶] 1. Rigor mortis. [¶] 2. Dependent lividity as evidenced by venous congestion (i.e., bruising or reddish discoloration on dependent parts of the body). [¶] 3. Tissue decomposition. [¶] 4. Obvious fatal trauma, including but not limited to, decapitation and incineration. [¶] Health care providers shall utilize the above criteria when deciding whether to initiate CPR. When there is a questionable or borderline case, health care staff shall proceed with the initiation of CPR. While preservation of a crime scene is a valuable investigatory tool, this shall not preclude or interfere with the delivery of health care. **Preservation of life takes precedence over preservation of a crime**

scene." Additionally, the parties stipulated, "No pulse, nonresponsiveness, no respiration, unconsciousness and fixed and dilated pupils are symptoms of death."[1]

In a proposed decision dated July 1, 2007 the ALJ defined the issues as whether Goleco had failed to provide the required medical care, failed to arrange for the immediate removal of Arriaga from the cell, made an improper medical assessment by stating Arriaga "was done" and had been dishonest during the investigation of the incident.[2] Recommending Goleco's dismissal be revoked, the ALJ found Goleco may have made some mistakes, but "Lt. Hughes was the biggest impediment to the inmate getting appropriate medical assistance from the staff." The ALJ also found Goleco "did the best he could under the circumstances," explaining Goleco, new on the job, was inexperienced and had not been properly trained to handle such an emergency. The ALJ further found Goleco had not been dishonest during the investigation but had had lapses in memory.

The Personnel Board rejected the ALJ's decision. On June 24, 2008, after written briefs and oral argument, the Personnel Board sustained Goleco's dismissal, concluding the Department established Goleco had "failed to provide adequate and timely emergency medical treatment to the inmate," grounds for discipline under Government Code section 19572, subdivision (d) (inexcusable neglect of duty) and subdivision (t) (other failure of good behavior). The Personnel Board found it should not have taken Goleco more than two minutes to assess Arriaga and to begin performing CPR; although Goleco had not received training from the Department on responding to emergencies such as a potential

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1 At oral argument counsel for the Department argued these signs of death, which Goleco observed when he encountered Arriaga, are not listed in the IERRC Guidelines as obviating the need to commence CPR. Collectively, however, they might reasonably indicate "obvious fatal trauma" (number four in the Guidelines' signs of death). Decapitation and incineration are listed only as examples—that is, "including but not limited to"—not the sole types of obvious fatal trauma that justify a decision not to initiate CPR.

2 Among its many deficiencies, the record on appeal does not include a copy of the October 2005 notice of adverse action.

homicide, "no evidence was presented to establish that [Goleco] needed specialized training to provide emergency care to the inmate, beyond that which he was required to possess to be appointed to the [medical technical assistant] classification"; the evidence established Goleco's primary concern should have been to begin CPR immediately and Arriaga's head wound "should have been a secondary concern"; and the other correctional officers' presence in and around the cell did not have any bearing on Goleco's actions, "as [Goleco] admitted that no [correctional officer] hindered him in his ability to perform his required duties."

Regarding the penalty of dismissal, the Personnel Board explained, "The public service is harmed when [a medical technical assistant] fails to provide emergency care in an expeditious manner. . . . [¶] . . . [Goleco's] failure to do so was not justified. Moreover, [Goleco] fails to acknowledge that it was unreasonable for him to delay performing CPR on the inmate for five minutes, thereby indicating that the likelihood of recurrence is high if [Goleco] is faced with a similar situation. [Goleco's] dismissal is, therefore, warranted."

3. *The Petition for Writ of Mandamus; the Supplemental Hearing and Decision*

In April 2009 Goleco petitioned the superior court for a writ of administrative mandamus (Code Civ. Proc., § 1094.5) to set aside the Personnel Board's decision and moved to augment the record with newly discovered evidence that had been admitted in a parallel case involving Lieutenant Hughes.[3] In Hughes's case Dr. David Posey, a forensic pathologist, opined (in a written report and testimony at an October 2007 hearing) that Arriaga had been dead for almost an hour when Goleco arrived and attempts to resuscitate him were futile. Additionally, an IERRC report dated July 26, 2005 found the staff's response time was adequate and compliance was appropriate.

Although the court found there was substantial evidence to support the Personnel Board's termination of Goleco based upon the record it had reviewed, the court granted

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3 This was a second amended petition. The initial petition was filed in October 2008.

Goleco's motion to augment the record. The court directed the Personnel Board to set aside its decision, hold an evidentiary hearing to permit Goleco to present the newly discovered evidence and reconsider its decision in light of the new evidence.

After a hearing in June 2010 before a different ALJ, the ALJ issued a proposed decision upholding Goleco's dismissal. The ALJ found the IERRC report included assertions about Arriaga's death and the staff's responsiveness that were "imprecise, unsupported, and contradicted by the supporting documents" and thus the report, "standing alone, [was] insufficient to undo other more specific, credible, and substantial evidence in the record establishing that [Goleco] unduly delayed taking life-preserving action." The ALJ further found Dr. Posey's opinion Arriaga had been dead for nearly one hour was essentially irrelevant: "[T]he academic question of when, exactly, the inmate died is not the decisive one, especially since the evidence establishes that [Goleco] was not qualified to pronounce the inmate dead. The decisive inquiry asks what did [Goleco] do, and how quickly did he do it, once he confronted a clearly non responsive inmate? Notwithstanding Dr. Posey's opinion to the contrary, a preponderance of the evidence establishes that [Goleco] inexplicably and dangerously delayed initiation of CPR to a non-responsive inmate—the very action *required* of MTAs in such scenarios." The Personnel Board adopted the decision in September 2010.

4. *The Superior Court's Grant of Goleco's Subsequent Petition for Writ of Mandamus*

In January 2011 Goleco again petitioned the superior court to set aside the Personnel Board's decision and to reinstate him with full back pay and lost employee benefits. In his brief in support of the petition filed in November 2011, Goleco argued substantial evidence did not support the conclusion he had inexplicably and dangerously delayed initiation of CPR given his lack of training, the Department's failure to conduct reviews and drills for emergency response procedures and the IERRC guidelines, which provide CPR need not be initiated when signs of death are present such as those Dr. Posey opined existed when Goleco encountered Arriaga. Goleco also argued "in [his] mind, the inmate was beyond the reach of resuscitation[. D]espite this, [Goleco] still

engaged in CPR." Goleco further asserted the Personnel Board's penalty of dismissal was excessive and an abuse of discretion.

At the commencement of trial on February 28, 2012, the court issued its tentative decision to grant Goleco's petition, applying the independent judgment standard of review. After the Department argued the substantial evidence standard was applicable, the court indicated it would reconsider its decision but did not think it would change the outcome: "That rigor mortis set in was visibly obvious, he was dead. And how the [Personnel B]oard could have concluded that somehow it would have been appropriate to begin CPR on this poor man is kind of beyond me. . . . [A]ll the obvious facts that are apparent to everyone on this date in that cell, that he been dead for some period of time. . . . I just don't think this is one where this poor guy could have done anything." On March 20, 2012 judgment was entered granting Goleco's petition.

DISCUSSION

1. *The Law Governing Discipline of State Civil Service Employees and the Standard of Review*

The Personnel Board enforces civil service statutes and reviews disciplinary actions. (*California Youth Authority v. State Personnel Board* (2002) 104 Cal.App.4th 575, 584 (*Youth Authority*); see Gov. Code, § 19578.) Because the Personnel Board is created by, and derives its adjudicatory powers from, the Constitution (Cal. Const., art. VII, §§ 2, 3), it acts much as a trial court in reviewing disciplinary actions, making factual findings and exercising discretion on matters within its jurisdiction. (*Youth Authority*, at p. 584.) Thus, both the superior court and an appellate court reviewing the superior court's ruling must uphold the Personnel Board's findings if they are supported by substantial evidence. (See *Coleman v. Department of Personnel Administration* (1991) 52 Cal.3d 1102, 1125-1126 ["[d]ecisions of the State Personnel Board, an agency of constitutional authority [citation], are reviewed only to determine whether substantial evidence supports the determination, even when vested rights are involved"].)

"'Substantial evidence' is relevant evidence that a reasonable mind might accept as adequate to support a conclusion." (*Youth Authority, supra*, 104 Cal.App.4th at

pp. 584-585.) The Personnel Board's findings "'come before us "with a strong presumption as to their correctness and regularity."'" (*Id.* at p. 584.) "'We do not reweigh the evidence; we indulge all presumptions and resolve all conflicts in favor of the [Personnel Board's] decision.'" (*Ibid.*) "'We do not substitute our own judgment if the [Personnel Board's] decision '"'"is one which could have been made by reasonable people. . . ."'"'" (*Ibid.*)

2. *The Department Has Failed To Carry Its Burden To Demonstrate Substantial Evidence Supports the Personnel Board's Decision To Terminate Goleco*

Notwithstanding the strong presumption of correctness that adheres to Personnel Board findings, a state agency seeking to overturn the superior court's decision to grant a petition for writ of mandate, like any appellant, bears the burden of demonstrating the superior court erred. This fundamental principle requires the appellant to provide an adequate record on appeal (see *Maria P. v. Riles* (1987) 43 Cal.3d 1281, 1295-1296), "[p]rovide a summary of the significant facts" (Cal. Rules of Court, rule 8.204(a)(2)(C); cf. *Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 881 [appellant challenging sufficiency of evidence must summarize all material evidence on point not merely appellant's own evidence]), and "[s]upport any reference to a matter in the record by a citation to the volume and page number of the record where the matter appears" (Cal. Rules of Court, rule 8.204(a)(1)(C)).

The Department's repeated failure to comply with these basic requirements compels us to affirm the trial court's decision.[4] The Department initially failed to lodge the administrative record. After this court informed the Department of the omission, the Department lodged a single-volume administrative record comprised of 298 pages. This lone volume, however, was obviously not the correct record because the Department's brief on appeal cites to pages with numbers higher than 298 and citations to pages

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4 Although we recognize state financial resources are limited and agency personnel, including legal counsel, are stretched, the Department's nearly total lack of compliance with the fundamental rules of appellate practice precludes meaningful review of the superior court's decision.

numbered below 298 do not correspond to the documents in the volume submitted. After this court advised the Department of this new deficiency, the Department lodged a three-volume administrative record. Yet again, this record is incomplete. Missing from the record, which begins on page numbered "1/1349" and ends on page numbered "1349/1349" are pages 419 through 820, some of which are cited in the Department's brief.

The Department's brief is similarly deficient. Its statement of facts includes a mere two paragraphs purporting to describe the testimony and evidence introduced during five days of hearings with 12 witnesses. The first paragraph is a brief, distorted summary of Goleco's testimony. The second two-sentence paragraph, which is key to the Department's argument Goleco's conduct fell below the standard of care, states, "Senior MTA Brenda Wimbish testified at the SPB hearing. She stated that the standard of care under these circumstances is that CPR must be initiated within one (1) minute or less." The Department cites to page 757 in the record, which is missing. The Department then makes two short arguments. First, Dr. Posey's opinion is not relevant; and the IERRC report is entitled to little, if any, weight. Second, substantial evidence supports the Personnel Board's decision. This latter argument is supported by a single sentence: "As recounted in the Board's decision, the testimony of MTA's Wimbish and Johnson establish that Goleco's delay in starting CPR represented a gross violation of the standard of care." Johnson's testimony is not mentioned in the statement of facts nor is there any citation to the portion of the record containing his testimony in the argument section of the brief. Indeed, three people with the last name Johnson testified (Danielle, Don and Kelly), and the Department does not provide a first name to indicate which Johnson's testimony supports the Personnel Board's finding.

Although it is not the proper function of the Court of Appeal to search the record on behalf of an appellant or to serve as "backup appellate counsel" (*Mansell v. Board of Administration* (1994) 30 Cal.App.4th 539, 545-546; see *Del Real v. City of Riverside* (2002) 95 Cal.App.4th 761, 768 ["it is counsel's duty to point out portions of the record that support the position taken on appeal"]), we have nevertheless reviewed the record.

We located Wimbish's testimony beginning at page 1148 of the record notwithstanding the citation to missing page 757. The only testimony to arguably support the Personnel Board's finding Goleco should have begun CPR within two minutes is Wimbish's answer to the question, "And how long would the ABCs [that is, airway, breathing and cardio] take for an MTA to determine doing the ABCs?" Wimbish replied, "Well, you immediately do your assessment of the patient and within—I would think—within definitely a minute or less, you would make the determination of whether or not you had—the patient was—had breathing, a heart rate, and start CPR." Wimbish's brief testimony about general procedures does not address the circumstances Goleco confronted, including signs of death as described in the IERRC guidelines, the conclusion and concomitant action taken by Lieutenant Hughes and other correctional officers that Arriaga was clearly dead, the extent of Arriaga's injuries and the absence of the primary medical technical assistant assigned to the unit. Even were we to agree little or no weight should be accorded to Dr. Posey's opinion and the IERRC report finding adequate staff response, it is not reasonable to extrapolate from Wimbish's testimony that Goleco's conduct was a gross violation of the standard of care in the instant case. Moreover, we were simply unable to find in the record testimony by senior medical technical assistant Don Johnson, who appears to be the Johnson referred to in the Personnel Board's June 24, 2008 decision. Accordingly, that missing testimony cannot possibly provide the basis for a substantial evidence finding.

DISPOSITION

The judgment is affirmed.

PERLUSS, P. J.

We concur:

WOODS, J. ZELON, J.